Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BONNIE LAMMERS, MD
PO BOX 121589
ARLINGTON TX 76012

Respondent Name

NETHERLANDS INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-10-4594-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid per the DWC Fee Guides"

Amount in Dispute: $375.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2010	99456-W7-RE and 99456-W6-RE	$375.00	$375.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated May 07, 2010.
   - 858-100 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. FEE GUIDELINE MAR REDUCTION. UMD RECOMMENDS $125.00
   - 858-100 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. FEE GUIDELINE

MAR REDUCTION. UMD RECOMMENDS $250.00
- W1 – Workers Compensation State Fee Schedule Adjustment $125.00
- W1 – Workers Compensation State Fee Schedule Adjustment $250.00

Explanation of benefits dated June 07, 2010
- 18 – Duplicate claim/services. $0.00
- 888 – DUPLICATE PAYMENT UMB RECOMMENDS $0.00

Per a phone conversation with requestor on September 15, 2011, an EOB from May 07, 2010 was provided via email. Previously, only a copy of the check for original payment amount was provided to MFDR but no payment/denial exception codes were available for that carrier EOB date.

Issues

1. Did the requestor support that disputed services were performed, documented, and billed in accordance with Texas Administrative Code, Section §134.204 and the DWC request for Designated Doctor services on the EES-14 notification form?
2. Is the requestor entitled to reimbursement?

Findings

1. The Respondent denied reimbursement based upon 18 – "duplicate claim/services. $0.00." and 888 – "DUPLICATE PAYMENT UMB RECOMMENDS $0.00." The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
2. Per 28 Texas Administrative Code §134.204, the services disputed were 99456-W7-RE and for determination of whether the employee's disability is a direct result of the work related injury and 99456-W6-RE for determination of the employee's compensable injury. Review of the submitted documentation finds that the DWC EES-14 notification specified Maximum Medical Improvement, Impairment Rating, Return to Work, Extent of Injury and Direct Result examinations were accomplished as requested. As the services in dispute were requested, and are to be reimbursed per 28 Texas Administrative Code §134.204(i) and (k).
3. Review of the submitted documentation shows that reimbursement is due for the MAR of $250.00 as a secondary RTW/EMC question and $125.00 for the third performed with a total of $375.00 due per 28 Texas Administrative Code §134.204.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $375.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $375.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 20, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.